PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per plan year)	$200 Employee $400 Family	$400 Employee $800 Family
All covered expenses, excluding prescription drugs, accumulate toward both the preferred and non-preferred Deductible. Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Members with a Family Deductible do not have an Individual Deductible to satisfy. Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the plan year.		
Member Coinsurance Applies to all expenses unless otherwise stated.	10%	30%
Coinsurance Limit (per plan year)	$1,000 Employee $2,000 Family	$3,000 Employee $6,000 Family
All covered expenses, excluding prescription drugs, accumulate toward both the preferred and non-preferred Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles, and copays (except any penalty amounts) may be used to satisfy the Payment Limit. Members with a Family Out-of-Pocket Maximum do not have an Individual Out-of-Pocket Maximum to satisfy Once Family Coinsurance Limit is met, all family members will be considered as having met their Coinsurance Limit for the remainder of the plan year.		
Lifetime Maximum Unlimited except where otherwise indicated.		
Primary Care Physician Selection	Not applicable	Not applicable
Certification Requirements - Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $300 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Routine Adult Physical Exams/ Immunizations 1 exam per 12 months	10% after $20 office visit copay	30%
Routine Well Child Exams/Immunizations 7 exams in the first 12 months of life, 2 exams in the 13th-24th months of life; 1 exam per 12 months thereafter to age 18.	10% after $20 office visit copay	30%
Routine Gynecological Care Exams Included with 1 Pap smear and related lab fees	Covered 100%	30%
Routine Mammograms One baseline age 35 -39 Annually age 40+	Covered 100%	30%
Routine Digital Rectal Exam / Prostate-specific Antigen Test - 1 Annual DRE & PSA For covered males age 40	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Colorectal Cancer Screening For all members age 50 and over.	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
PHYSICIAN SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Office Visits to Non-Specialist (non-surgical) Includes services of an internist, general physician, family practitioner or pediatrician.	10% after $20 office visit copay	30%
Specialist Office Visits (non-surgical)	10% after $20 office visit copay	30%
Office Visits for Surgery	10%	30%
Allergy Testing	Covered as either PCP or specialist office visit	30%
Allergy Injections	10%	30%
DIAGNOSTIC PROCEDURES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Diagnostic Laboratory and X-ray If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing	10%	30%
EMERGENCY MEDICAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Urgent Care Provider (benefit availability may vary by location)	10% after $25 copay	30%
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	10% after $50 copay	Same as preferred care.

Non-Emergency care in an Emergency Room	50%	50%
Ambulance	10%	30%
HOSPITAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient Coverage	10%	30%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Inpatient Maternity Coverage	10%	30%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient Hospital Expenses (including surgery)	10%	30%
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
MENTAL HEALTH SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient	10%	30%
Unlimited.		
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	80% after deductible for 1st 5 visits, 65% after deductible for 6-30ths visits,	
Unlimited	50% after deductible thereafter	
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
ALCOHOL/DRUG ABUSE SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient	10%	30%
Limited to 30 days per calendar year.		
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	80% after deductible for 1st 5 visits, 65% after deductible for 6-30ths visits,	
Unlimited	50% after deductible thereafter	
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
OTHER SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Convalescent Facility	10%	30%
Limited to 120 days per calendar year.		
The member cost sharing applies to all covered benefits incurring during a member's inpatient stay		
Home Health Care	Covered 100%	30%
Limited to 120 visits per calendar year.		
Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.		
Hospice Care - Inpatient	10%	30%
Unlimited		
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Hospice Care - Outpatient	10%	30%
Unlimited		
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
Private Duty Nursing - Outpatient (Limited to 70 eight hour shifts per plan year)	10%	30%
Outpatient Short-Term Rehabilitation	10%	30%
Limited to 60 visits per calendar year.		
Includes speech, physical, and occupational therapy.		
Spinal Manipulation Therapy	10% after $20 copay	30%
Limited to 20 visits per calendar year		
Durable Medical Equipment	10%	30%
Diabetic Supplies	Covered same as any other medical expense.	Covered same as any other medical expense.
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	10% (payable as any other covered expense)	30% (payable as any other covered expense)
Transplants	10% Preferred coverage is provided at an IOE contracted facility only	30% Non-Preferred coverage is provided at a Non-IOE facility.
FAMILY PLANNING	**PREFERRED CARE**	**NON-PREFERRED CARE**
Infertility Treatment Diagnosis and treatment of the underlying medical condition.	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Comprehensive Infertility Services	10%	30%
Coverage includes Artificial Insemination (limited to six courses of treatment per member's lifetime) and Ovulation Induction (limited to six courses of treatment per member's lifetime). Lifetime maximum applies to all procedures covered by any Aetna plan except where prohibited by law.		
Advanced Reproductive Technology	10%	30%
ART coverage includes: In vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery.		
Voluntary Sterilization Including tubal ligation and vasectomy	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
PHARMACY	**PREFERRED CARE**	**NON-PREFERRED CARE**

Retail	$10 copay for generic drugs, $20 copay for formulary brand-name drugs, and $35 copay for non-formulary brand-name drugs. Up to a 90 day supply for 3X the copay.	$10 copay for generic drugs, $20 copay for formulary brand-name drugs, and $35 copay for non-formulary brand-name drugs. Up to a 90 day supply for 3X the copay.
Mail Order	$10 copay for generic drugs, $20 copay for formulary brand-name drugs, and $35 copay for non-formulary brand-name drugs up to a 90 day supply from Aetna Rx Home Delivery®.	Not Covered

Pharmacy Managed Self Injectables (PMSI)
First prescription fill at any retail or mail order drug facility. Subsequent fills must be through Aetna Speciality Pharmacy®

No Mandatory Generic (NO MG) - Member is responsible to pay the applicable copay only.

Plan Includes: Performance Enhancing Medication, Contraceptive drugs and devices obtainable from a pharmacy, Oral fertility drugs, Injectable fertility drugs (physician charges for injections are not covered under RX, medical coverage is limited), Diabetic supplies.

Precert for growth hormones included

GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 25.
Pre-existing Conditions Exclusion	On effective date: Waived After effective date: Full Postponement

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any eye surgery mainly to correct refractive errors; Cosmetic surgery, including breast reduction; Custodial care; Dental care and X-rays; Donor egg retrieval; Experimental and investigational procedures; Hearing aids; Immunizations for travel or work; and other related services, unless specifically listed as covered in your plan documents;

Nonmedically necessary services or supplies; Orthotics; Over-the-counter medications and supplies; Reversal of sterilization; Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing. Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan.
With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.
Some benefits are subject to limitations or visit maximums. Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. When the member utilizes a non-preferred provider, Member must obtain the precertification. Precertification requirements may vary. Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available under plans with an open formulary or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary. They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not avai

Plans are provided by Aetna Life Insurance Company.